

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-04-8917.M5**

**MDR Tracking Number: M5-04-3080-01**

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 5-17-04.

In accordance with Rule 133.307 (d), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 05-17-04, therefore the following date(s) of service are not timely and are not eligible for this review: 01-14-03 through 04-24-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the Hydroco/Apap, Carisoprodol, Triazolam, Viagra, Diazepam, and Atenolol from 5-28-03 through 05-13-04 were not medically necessary.

In accordance with Rule 133.307 (d), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 05-17-04, therefore the following date(s) of service are not timely and are not eligible for this review: 01-14-03 through 04-24-03.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 5-28-03 through 05-13-04 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 23<sup>rd</sup> day of July 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

DA/da

## **MEDICAL REVIEW OF TEXAS**

[IRO #5259]

**3402 Vanshire Drive**

**Austin, Texas 78738**

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### **NOTICE OF INDEPENDENT REVIEW DETERMINATION**

TWCC Case Number:
MDR Tracking Number: M5-04-3080-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

July 19, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating

physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

#### CLINICAL HISTORY

The following material was reviewed:

1. Office notes/evaluation by Dr. W; 1/2002-4/2004; and
2. Office note: history and physical by Dr. K, 1/26/99.

56-year old male status post back injury on \_\_\_\_, with persistent lumbar syndrome and shoulder enthesopathy.

#### REQUESTED SERVICE(S)

Hydrocodone/APAP, Carisoprodol, Triazolam, Viagra, Diazepam, Atenolol.

#### DECISION

Uphold denial.

#### RATIONALE/BASIS FOR DECISION

There is no proven effectiveness for use of any of these medications for chronic spine or enthesopathy pain. Please refer to Jerome Schofferman, MD in *The Low Back Pain Handbook* and the *North American Spine Society Clinical Guidelines*.